N. **Supplemental Payment Adjustments to Nursing Facilities Operated by Public Authorities.** A supplemental payment adjustment shall be computed for certain publicly owned or publicly operated nursing facilities that meet the criteria described herein. Qualifying nursing facilities shall receive a MassHealth supplemental payment annually for each applicable fiscal year. To be eligible for this payment adjustment, the nursing facility must be a publicly owned or publicly operated nursing facility that meets all of the following criteria:

1. a public authority, which is created under Massachusetts state law to serve an essential public purpose in the Commonwealth of Massachusetts, must own or operate the nursing facility;

2. at least 50% of the nursing facility's patient days are paid by the Mass Health program; and

3. the nursing facility must participate in the Mass Health program under a specially designated Mass Health provider contract applicable to a Massachusetts public authority.

The amount of any supplemental payment adjustment will be specified in the MassHealth provider contract applicable to a Massachusetts public authority. The adjustment may provide financial support to the nursing facility relative to any changes it makes in its practices, scope of services, care quality management, or other improvement that is made in accordance with the purposes, goals, and terms specified in the MassHealth provider contract applicable to a Massachusetts public authority. Any supplemental payment adjustment shall be computed in the aggregate, in supplementation to the standard nursing facility payment rates. The payment amount for each qualifying nursing facility will be calculated by the Division and will be equal to each qualifying facility's pro-rata share of: the difference between the aggregate upper-limit calculated ceiling for all public nursing facilities and each qualifying facility's standard MassHealth reimbursement. Pro-rata share for each qualifying facility will be determined based on each qualifying facility's MassHealth patient days as a percentage of total MassHealth patient days for qualifying facilities. The most recently completed MassHealth cost report will be used as the source document for the MassHealth patient day statistics.

For purposes of calculating a reasonable estimate of the non-state publicly owned nursing facility upper payment limit (UPL) using Medicare payment principles, actual Medicare payments for non-state publicly owned nursing facilities are identified using the most recently filed MassHealth nursing facility cost report as the source document. Total Medicare payments for each non-state publicly owned nursing facility are divided by each facility's Medicare patient days to calculate a facility specific Medicare payment per diem. For any facility that did not report Medicare payments and days on its cost report, an average Medicare payment per diem is used as a proxy, based on the data filed by the other non-state publicly owned nursing facilities. To account for differences in coverage and acuity, the Medicare payment per diem for each facility is adjusted downward by applying the Medicare therapy/ancillary percentage of the Medicare calculated PPS SNF federal rate to carve out these ancillary services from the Medicare per diem. This discount factor, as published in the Federal Register dated July 30, 1999, was 36% of the PPS SNF federal rate and results in a 36% reduction in the Medicare per diem that is used in the UPL calculation. This discount factor effectively removes therapy/ancillary services from the UPL methodology and leaves only the core nursing/room and board services. This adjusted Medicare per diem is updated for inflation using the national average increase in Medicare skilled nursing facilities and is then multiplied by facility specific MassHealth patient days. The resulting amounts for each non-state publicly owned nursing facility are then added together to calculate the aggregate MassHealth UPL ceiling. This UPL ceiling calculation is then compared to the standard MassHealth reimbursement under the State Plan methodology in order to calculate the supplemental payments available under Section IV.N to qualifying facilities.

O. **Appeals.** A provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after DHCFP files the rate with the State Secretary. DHCFP may amend a rate or request additional information from the provider even if the provider has filed a pending appeal.

Appendices to Attachment 4.19-D(4)

Appendix A: 114.2 CMR: 6.00 (Division of Health Care Finance and Policy)

Appendix B: Division of Medical Assistance Nursing Facility Bulletin 115, Ancillary Pilot Project

Appendix C: M.G.L. c.111 s.72N

114.2 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

Section

6.01: General Provisions

(1) Scope and Effective Date. 114.2 CMR 6.00 governs the payments effective July 1, 2002 through December 31, 2002 and January 1, 2003 through June 30, 2003 for services rendered to Publicly Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility.
(2) Authority. 114.2 CMR 6.00 is adopted pursuant to M.G.L. c. 118G

6.02: General Definitions

As used in 114.2 CMR 6.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 6.00 are capitalized.

Actual Utilization Rate. The occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units that may or may not be accompanied by an increase in Licensed Bed Capacity.

Administrative and General Costs. Administrative and General Costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; worker's compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisement; licenses and dues, resident-care related; education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs. For facilities organized as sole proprietors or partnerships and for which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits, administrative and general costs shall include an imputed value of $69,781 to reflect the costs of such services.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Audit. An examination of the Provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Building. Building Costs include the direct cost of construction of the structure that houses residents and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures made a

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permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

Capital Costs. Capital Costs include Building Depreciation, Financing Contribution, Building Insurance, Real Estate Taxes, non-income portion of Massachusetts Corp. Excise Taxes, Other Rent and Other Fixed Costs.

Case-Mix Category. One of six categories of resident acuity that represents a range of Management Minutes.

Change of Ownership. A bona fide transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the Provider rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g. drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Department. The Massachusetts Department of Public Health.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to the Building, including such items as beds, tables, and wheelchairs.

Financing Contribution. Payment for the use of necessary capital assets whether internally or externally funded.

Generally Available Employee Benefits. Employee benefits that are nondiscriminatory and available to all full-time employees.

Hospital-Based Nursing Facility. A separate Nursing Facility Unit or Units located in a hospital building licensed for both hospital and Nursing Facility services in which the Nursing Facility licensed beds are less than a majority of the facility's total licensed beds and the Nursing Facility patient days are less than a majority of the facility's total patient days. It does not include free-standing Nursing Facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the Provider is in some way better than it was before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the Provider's increased productivity, greater capacity or longer life.

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Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, et seq.

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Major Addition. A newly constructed addition to a Nursing Facility that increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A method of measuring resident care intensity, or case mix, by discrete care-giving activities or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the Division of Medical Assistance.

Massachusetts Corporate Excise Tax. Those taxes that have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of licensed beds for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A Provider's weighted average Licensed Bed Capacity for the calendar year, determined by (1) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level and (2) adding the Maximum Available Bed Days for each level and (3) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Mortgage Acquisition Costs. Those costs (such as finder's fees, certain legal fees, and filing fees) necessary to obtain long-term financing through a mortgage, bond or other long-term debt instrument.

New Facility. A Nursing Facility that opens on or after January 1, 2000. A Replacement Facility is not a New Facility.

Nursing Costs. Nursing costs include the 2000 Reported Costs for Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, and the Workers Compensation expense, Payroll Tax expense, and Fringe Benefits, including Pension Expense, associated with those salaries.

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Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, s.71; or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

Other Fixed Costs. Other Fixed Costs include Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment, the Non-Income portion of the Massachusetts Corporate Excise tax, Building Insurance, and Rental of Equipment located at the facility.

Other Operating Costs. Other Operating Costs include, but are not limited to the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical Director; Advisory Physician; Utilization Review Committee; Employee Physical Exams; Other Physician Services; House Medical Supplies Not Resold; Pharmacy Consultant; Social Service Worker; Indirect Restorative and Recreation Therapy Expense; Other Required Education; Job Related Education; Quality Assurance Professionals; Management Minute Questionnaire Nurses; Staff Development Coordinator; Motor Vehicle Expenses including, but not limited to depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and Administrative and General Costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a Provider reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the Division of Medical Assistance. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

Private Nursing Facility. A Nursing Facility that formerly served only non-Medicaid residents and does not have a provider agreement with the Division of Medical Assistance to provide services to public Residents.

Provider. A Nursing Facility providing care to Publicly Aided Residents or Industrial Accident Residents.

Prudent Buyer Concept. The assumption that a purchase price that exceeds the market price for a supply or service is an unreasonable cost.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Related Party. An individual or organization associated or affiliated with, or that has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% is the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Replacement Facility. A Nursing Facility licensed prior to January 1, 2000 that replaces its entire building with a newly-constructed facility pursuant to an approved Determination of Need under 105 CMR 100.505(a)(6). A facility that renovates a building previously licensed as a nursing facility is not a Replacement Facility.

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Reported Costs. All costs reported in the cost report, less costs adjusted and/or self-disallowed in Schedules 13 and 14 of the 2000 cost reports.

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility licensed by the Department to provide residential care.

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (Licensing of Long-Term Care Facilities).

6.03: Nursing

(1) Nursing Standard Payments. All facilities will be paid at the following Nursing Standard Payments:

Payment Group	Management Minute Range	Standard Payment
H	0 - 30	$10.95
JK	30.1 – 110	$28.48
LM	110.1 – 170	$51.40
NP	170.1 – 225	$72.28
RS	225.1 – 270	$90.76
T	270.1 and above	$108.80

6.04: Other Operating Costs.

(1) Other Operating Cost Standard Payments. All facilities will be paid at the Standard Payments. The Other Operating Cost Standard Payment for each Payment Group is $56.05.

6.05 Capital

(1) Capital Payment. There will be a capital payment, as listed in 6.05(1)(d), for facilities included in 6.05(1)(a), (b) and (c):

(a) New Facilities and Licensed Beds that become operational on or after February 1, 1998 and are:

1. New Facilities constructed pursuant to a Determination of Need approved after March 7, 1996;
2. Replacement facilities replaced pursuant to a Determination of Need approved after March 7, 1996;

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3. New Facilities constructed in Urban Underbedded areas exempt from the Determination of Need process;
4. New beds licensed pursuant to a Determination of Need approved after March 7, 1996; and
5. New beds in twelve-bed expansion projects not associated with an approved Determination of Need project.

(b) Hospital-Based Nursing Facilities ; and
(c) Private Nursing Facilities that sign a Provider Agreement with the Division of Medical Assistance after the effective date of this regulation.
(d) The capital payment will be as follows:

Date that New Facilities and Licensed Beds Became Operational	Payment Amount
Prior to February 1, 1998 (for hospital-based nursing facilities only)	$17.29
February 1, 1998 – December 31, 2000	$17.29
January 1, 2001 – June 30, 2002	$18.24
July 1, 2002 – December 31, 2002	$20.25
January 1, 2003 – June 30, 2003	$20.25

(2) Capital Payment – Other Facilities. For all other facilities, the Capital Payment is based on the facility's Capital Costs, including allowable depreciation, Financing Contribution, and Other Fixed Costs. (a) Allowable Basis of Fixed Assets.

1. Fixed Assets include Land, Building, Improvements, Equipment and Software.
2. Allowable Basis. The Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council and used for Nursing Facility services. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.
3. Allowable Additions. The Division will recognize Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions relate to a capital project for which the Department has established a Maximum Capital Expenditure, the allowable amount will be limited to the amount approved by the Department. The Division will not recognize Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.
4. Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:
   a. Land. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis.
   b. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June, 30, 1976 and 1993 forward.
   c. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

d. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

e. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

f. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.

5. Special Provisions.

a. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

b. Repossession by Transferor. The Division will recalculate Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership, increased by any allowable capital Improvements made by the transferee since acquisition, and reduced by depreciation since acquisition.

(b) Capital Costs. The Division will calculate the Provider's Capital Costs including depreciation, Financing Contribution, and Other Capital Costs as defined below.

1. Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets as of December 31, 2000. Depreciation of Buildings, Building Improvements, and Equipment will be allowed based on generally accepted accounting principles using the Allowable Basis of Fixed Assets, the straight line method, and the following useful lives:

LIFE	YEARS	RATE
Buildings and Additions	40	2.5%
Building Improvements	20	5%
Equipment, Furniture and Fixtures	10	10%
Software	3	33.3%

2. Financing Contribution. The Division will calculate a Financing Contribution by multiplying 7.625% by the Allowable Net Book Value as of December 31, 2000. The Allowable Net Book Value is the allowable basis less all accumulated depreciation calculated for the period through December 31, 2000, except allowed Building depreciation expense that occurred between January 1, 1983 and December 31, 1992.

3. Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment at the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.

4. Capital Costs. The Division will calculate the Provider's Capital Costs by adding allowable 2000 depreciation and Other Fixed Costs and the Financing Contribution.

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5. Capital Cost Per Diem. The Division will calculate the Provider's 2000 Capital Cost per diem by dividing 2000 Capital Costs by the greater of 96% of Constructed Bed Capacity times 365 or the Actual Utilization Rate in 2000.
6. For Providers with a revised Capital Payment for a substantial capital expenditure in 2001, the Division will calculate Capital Costs using the year end Allowable Basis and Net Book Value, revised constructed bed capacity, and revised Actual Utilization Rate. This does not apply to Providers with a revised Capital Payment of $17.29 or $18.24.

(c) Determination of Capital Payment. For beds licensed prior to July 2002, the Capital Payment will be calculated as follows:

1. If the Provider's January 2002 Capital Payment is lower than $17.29, and its Capital Cost per diem is greater than $17.29, its Capital Payment is $17.29.
2. If the Provider's January 2002 Capital Payment is lower than $17.29, and its Capital Cost per diem is lower than $17.29, its Capital Payment is its Capital Cost per diem.
3. If the Provider's January 2002 Capital Payment is greater than $17.29, and its Capital Cost per diem is greater than $17.29, its Capital Payment is the greater of $17.29 or 90% of its Capital Cost per diem, but no greater than their January 2002 Capital Payment.
4. If the Provider's January 2002 Capital Payment is greater than $17.29, and its Capital Cost per diem is lower than $17.29, its Capital Payment is $17.29.
5. If the Provider's January 2002 Capital Payment is $17.29, Capital Payment is $17.29.
6. If the Provider's January 2002 Capital Payment is $18.24 and is based on a Determination of Need approved after March 7, 1996, its Capital Payment is $18.24.
7. If a Provider relicenses beds in 2001 that were out of service, its Capital Payment will be the lower of $17.29 or the facility's most recent billing rates for Fixed Costs and Equity or Use and Occupancy.
8. If the Provider's Capital Payment is based on a Determination of Need approved prior to March 7, 1996, and the Provider receives a temporary Capital Payment in accordance with 6.05(3)(b)(3), then the Division will revise the Provider's Capital Payment in accordance with 6.05(3)(b)(4).

(d) Weighted Capital Payment. If a Provider's licensed beds fall into different Capital Payment methods, the Division will calculate the Capital Payment for each type of licensed beds. The Division will weight the capital payment based on the number of licensed beds associated with each type of method.

(3) Revised Capital Payment for Substantial Capital Expenditure.

(a) General Notification Requirements. All Providers must notify the Division when they open, add new beds, renovate or re-open beds. The notification must contain the Provider's name, address and VPN, date of bed change, type of change and description of project.
(b) Request for Revised Capital Payment. A Provider may request a revised Capital Payment for capital costs associated with the change or renovation of licensed beds pursuant to an approved Determination of Need.

1. Facilities that may request a revised Capital Payment include:
   a. New Facilities and newly-licensed beds that open pursuant to a Determination of Need;
   b. Replacement Facilities that open on or after July 1, 2002 pursuant to a Determination of Need;
   c. Facilities with Renovations made pursuant to a Determination of Need;

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d. Facilities with twelve bed additions associated with a Determination of Need; and

e. Facilities that requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).

2. If a Provider listed in 114.2 CMR 6.05(3)(b)1 requests a revised Capital Payment to reflect a change in beds, it must submit the following:

a. a description of the project;

b. a copy of the construction contract;

c. copies of invoices and cancelled checks for construction costs;

d. a copy of the Department's licensure notification associated with the new beds; and

e. a copy of the mortgage.

The Division may request further information it determines necessary to calculate a revised Capital Payment.

3. The Division will certify a temporary Capital Payment of $20.25 upon receipt of the notification of the change in beds, rate adjustment request, and required supporting documentation.

4. If the Provider's Capital Payment is based on a Determination of Need approved prior to March 7, 1996, in order to calculate the final revised Capital Payment the Division will determine the amount of new allowable assets and apply the Financing Factor in 114.2 CMR 6.05(2)(b)2.

(c) Revised Capital Payment.

1. For the Providers specified in 114.2 CMR 6.05(1)(a), the Division will certify a Capital Payment of $20.25.

2. For the following facilities, the final revised Capital Payment will be the greater of 90% of the amount calculated under 114.2 CMR 6.05(3)(b)4 or $20.25:

a. New Facilities and newly-licensed beds that open pursuant to a Determination of Need approved on or before March 7, 1996;

b. Replacement Facilities that open on or after July 1, 2002 pursuant to a Determination of Need approved on or before March 7, 1996;

c. Facilities with twelve bed additions associated with a Determination of Need approved on or before March 7, 1996; and

d. Facilities that requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).

3. For the following facilities, the revised Capital Payment will be the lower of the amount calculated under 114.2 CMR 6.05(3)(b)4 or $20.25:

a. facilities that renovate pursuant to a Determination of Need approved after March 7, 1996; and

b. facilities that implement a transferred Determination of Need approved before March 7, 1996 but did not file a Notice of Intent to Acquire the facility before March 7, 1996. This provision will not apply if the transfer occurred on or after February 1, 1998 and before May 30, 1998. If the transfer occurred during this period, the revised Capital Payment will be determined under 114.2 CMR 6.05(3)(c)1.

4. For Facilities with Renovations made pursuant to a Determination of Need approved before March 7, 1996, if the revised amount calculated under 114.2 CMR 6.05(3)(b)4 is greater than $20.25, the Capital Payment will be the 90% of the amount calculated under 114.2 CMR 6.05(3)(b)4. If the calculated amount is lower than $20.25, the Capital Payment will be the amount calculated under 114.2 CMR 6.05(3)(b)4.

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(d) Effective Date. The effective date of the revised Capital Payment will be the date upon which the Provider submits the notification and all information and documentation required in 114.2 CMR 6.05(3)(b)2.

6.06 Other Payment Provisions

(1) Add-on for Certified Nursing Assistants. Pursuant to Chapter 177 of the Acts of 2001, line item 4000-0600, the Division will include an add-on for Certified Nursing Assistants. This add-on is for the sole purpose of funding increases in Certified Nursing Assistant salaries and associated payroll taxes.. Any Provider that failed to file a required 1998, 1999 or 2000 cost report will not be eligible for this add-on.

(a). Calculation of the Add-on.

1. For each Provider, the Division will determine the total reported 1998 Certified Nursing Assistant Salaries.
   a. If the Division used a short year 1998 cost report to calculate the Provider's 2000 rate, the Division will annualize the reported Certified Nursing Salaries for that Provider.
   b. If a Provider opened after 1998, the Division will calculate the add-on using 1998 median reported Certified Nursing Assistant Salaries.
2. The Division will multiply the Provider's 1998 Certified Nursing Assistant Salary amount by the Provider's 1998 Medicaid Utilization as reported in the 1998 Cost Report. Medicaid Utilization is Total Reported Medicaid Days divided by Total Reported Patient Days.
3. The Division will sum the amount determined in 114.2 CMR 6.06(1)(c)1b for all Providers.
4. For each Provider, the Division will divide the amount determined in 114.2 CMR 6.06(1)(c)1b by the amount determined in 114.2 CMR 6.06(1)(c)1c.
5. The Division will multiply the resulting percentage by $40 million.
6. The Division will divide the amount calculated above by the product of:
   a. current licensed bed capacity for the period July 1, 2002 through June 30, 2003 , times 365,
   b. reported 2000 Actual Utilization, times
   c. reported 2000 Medicaid Utilization.

   This amount will be included as an add-on to each Provider's rate.

(b) Certified Nursing Assistant Add-on Recovery.

1. Permissible uses of CNA add-on revenue. Providers must use the add-on revenue solely to increase base hourly wages and payroll taxes for Certified Nursing Assistants. Effective January 1, 2002, such wage increases must be over and above any previously collectively bargained for wage increases. Such revenue may not be spent on overtime, non-permissible bonuses, or additional CNA hours. Providers may not use the add-on revenue to fund retroactive wage increases. In the following calculations:

a. CNA wages exclude overtime unless otherwise noted or non-permissible bonuses; CNA hours exclude overtime hours, unless otherwise noted.
b. the term "average hourly wages" includes wages and payroll taxes. A portion of revenue may be used to pay permissible bonuses subject to the limitations set forth below.
c. If a provider had a collective bargaining agreement in effect as of April 1, 2000, the Division will exclude the dollar amounts attributable to salary

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increases paid in accordance with the agreement for periods beginning on or after April 1, 2000.

(c). Compliance Monitoring. The Division will monitor each Provider to determine if it has increased CNA base hourly wages by at least the amount of the CNA add-on revenue. Providers that have collective bargaining agreements with any or all CNAs employed by the facility must demonstrate to the Division that the wage increases have been paid over and above these agreements.

(d). Calculation of Recovery Amount. Any provider that fails to spend 2002 CNA add-on revenue on CNA wage increases, payroll taxes, and permissible bonuses will be required to pay 150% of the unspent funds to the CNAs employed at the facility.

1. Calculation of Add-on Revenue. This is the total amount of revenue the facility received during 2002 for the purposes of increasing base wages to CNAs. The Division will multiply the 2002 CNA add-on by Medicaid patient days in 2002 to determine the Medicaid revenue generated by the add-on.

2. Estimated Target Wage Increase. This is the estimated wage increase based on the average hourly CNA wages in the base period, which is the first quarter of 2000. This amount is (1) the product of the Provider's 2002 CNA add-on times its annualized first quarter 2000 Medicaid days divided by (2) the Provider's annualized first quarter 2000 CNA hours.

3. 2002 Average Hourly Wage Increase. This is the total amount of increase in the average hourly wage given as a result of the add-on. This is the difference between (1) the Provider's average hourly wage in the base period (first quarter 2000 CNA wages and payroll taxes divided by the Provider's CNA hours in the first quarter of 2000) and (2) the average hourly wage (2002 CNA wages and payroll taxes, less amounts attributable to increases in salary expenses resulting from collective bargaining agreements for the period April 1, 2000 through December 31, 2002, divided by CNA hours in 2002).

4. Actual Target Wage Increase. This amount is determined by dividing the Provider's 2002 add-on revenue by the Provider's 2002 CNA hours.

5. Test One. The Division will determine the amount that the Provider should have increased wages based on the actual revenue received and the actual hours paid during 2002. To determine the required increase:

a. If 2002 CNA hours are lower than or equal to first quarter annualized 2000 CNA hours, the Division will divide 2002 add-on revenue by 2002 CNA hours;

b. If 2002 CNA hours are greater than first quarter annualized 2000 CNA hours, the Division will divide 2002 add-on revenue by annualized first quarter 2000 CNA hours.

If the Provider's 2002 Average Hourly Wage Increase exceeds the applicable amounts, the Provider is not subject to a recovery. If the Provider's 2002 average hourly wage increase is less than these amounts, the Provider will be subject to a recovery unless it qualifies for and has paid a sufficient permissible bonus under Test Two.

6. Test Two: Permissible Bonuses. A provider may fail Test One because of variances in Medicaid days or CNA hours. In these cases, a provider may pay unspent funds to the CNAs in the form of a permissible bonus. These permissible bonuses fall into two categories:

a. The Division will permit a Provider to spend up to 10% of the lower of its Estimated or Actual Target Wage Increase as a permissible bonus to account for variances. Bonuses or wages paid pursuant to collective bargaining agreements do not qualify as permissible bonuses and will be excluded from all Test Two

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